



## REQUIRED DOCUMENTATION CHECKLIST

(ALL COPIES MUST BE CLEAR)

***The Documentation Below Must Be In Your File Prior To Any Assignment.***

### **Application Materials (forms provided in this document)**

1. Job **Application** must be completed in full. Please print or type neatly. You may include your **resume**, but it will not replace a complete job application.
2. **Clinical Skills Checklist** (Neonatal and OR in addition, if applicable).
3. Signed Job Description.
4. **Two** references and/or written references on letterhead or a performance evaluation with **one** other reference.
5. State Criminal Back Ground Check with in the last 6 months.

### **Medical Documentation (you may use the forms attached or provide clear, original copies with a Doctor's signature and an official stamp)**

5. A current physical or physician's statement within previous 12 months.
6. Hepatitis B documentation (vaccination series of three, titer, booster, or signed declination).
7. A TB screen current within 12 months or chest X-ray current within two years.

### **Licenses, Professional Certifications, and Resuscitation Credentials**

8. Clear copies of all current nursing **licenses** and professional certifications.
9. Clear copy of a **current CPR** card. If you have additional resuscitation credentials (**ACLS**, ENPC, NRP, PALS, TNCC).
13. Proof of eligibility to work within the United States (For example: a Social Security Card and a Driver's License, or Passport).

**All the above items must be in your *completed* nurse file before your file is faxed to a facility for any assignment.**

**Please make sure that you include the highlighted items above with your application**

**Thank you for applying with Rehability Care**

14902, Shelborne Road, Westfield, IN 46074  
Phone: (317)286-2885 | Fax: (317)536-3097



RN		LPN	
SPL		PT	
PTA		OT	
COTA		OTHER	

### Personal Information

Name		Date
Social Security #		Date of Birth
Present Address		
City	State	Zip
Home Phone ( )		Other Phone ( )
Has your license or certification ever been under investigation?		Yes <input type="checkbox"/> No <input type="checkbox"/>
CPR Expiration	Date of Last Physical Exam	Date of Last TB
Have you been convicted of a felony or a misdemeanor within the last 5 years?		Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please describe		
Are you eligible to work in the United States?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Drivers License #	State	
Name of person to be notified in case of an emergency		Phone ( )

### Additional Information

Do you have any physical limitations that preclude you from performing any work for which you are being considered?	
Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, what can be done to accommodate your limitation	

### Licensure and Certifications

PPD Test	Date Given	Date Read	Induration	Negative	Positive
Step 1				<input type="checkbox"/>	<input type="checkbox"/>
Step 2				<input type="checkbox"/>	<input type="checkbox"/>
Chest X-Ray	Date	Results (Results must be attached)			

### Employment Desired

Position	Date available for work	Salary Desired
Are you currently employed? <input type="checkbox"/>	If so, may we contact your present employer? <input type="checkbox"/>	
By whom were you referred to us?		

### Education

Name	Location	Graduated (Y/N)	Degree

## Personal References

Name	Name
Address	Address
Phone ( )	Phone ( )

## Employment Experience

Employer	Address	
Position	From	To
Supervisor	Phone	
Reason for leaving?	May we contact your supervisor?	YES <input type="checkbox"/> NO <input type="checkbox"/>

Employer	Address	
Position	From	To
Supervisor	Phone	
Reason for leaving?	May we contact your supervisor?	YES <input type="checkbox"/> NO <input type="checkbox"/>

Employer	Address	
Position	From	To
Supervisor	Phone	
Reason for leaving?	May we contact your supervisor?	YES <input type="checkbox"/> NO <input type="checkbox"/>

## Experience

Area	Experience in last 3 years	Area	Experience in last 3 years	Area	Experience in last 3 years	Area	Experience in last 3 years
Alcohol Detox		Labor & delivery		Oncology		Psychiatric	
Burns		Medical Floor		Operating Room		Rehabilitation Care	
Cardiac Care		Medications		Orthopedics		Surgical Floor	
Doctor's Office		Neurological		OB/GYN		Urology	
Home Healthcare		Nursery		Pediatrics		Private Duty	
Intensive Care		Nursing Home					

I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed, falsified statements on this application shall be grounds for dismissal. I authorize investigation of all statements contained herein and the references listed above to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release all parties from all liability for any damage that may result from furnishing same to you. I understand and agree that, if hired, my employment is for no definite period and may, regardless of the date of payment of my wages and salary be terminated at any time without prior notice. I understand that I am not to transport patients in my automobile, nor am I to drive patients in the patient's automobile without written consent from the Rehability Care Office.

I agree, I will not seek or accept employment, either directly or indirectly in any capacity from any client of Rehability care to whom I have been assigned for at least 90 days after the last day of that assignment. I further understand that I cannot be paid until I present a time slip signed by both the client and me to the Rehability Care office.

Name of Applicant \_\_\_\_\_ Date \_\_\_\_\_

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_



\_\_\_\_\_ Traveling Nurse

\_\_\_\_\_ PRN Nurse

## REGISTERED NURSE JOB DESCRIPTION

### OVERVIEW:

The registered nurse is a health care professional that possesses a distinct body of knowledge. This knowledge is obtained through educational and professional experience.

### QUALIFICATIONS:

1. Currently licensed in the state as a registered nurse.
2. Currently CPR certified.
3. Minimum of 1 year current clinical experience.
4. Documentation of current immunization or proof of immunity (titers).
5. The ability to perform tasks involving physical activity, which may include heavy lifting, bending and prolonged standing.
6. Must pass appropriate skills tests.
7. Adheres to all policies and procedures of REHABILITY CARE and assigned facility.
8. The ability to communicate effectively.

### RESPONSIBILITIES:

1. Performs nursing care using sound judgment.
2. Implements physician's orders in a safe and accurate manner.
3. Transcribes and implements new physician orders.
4. Assists with admitting, discharging and transferring patients.
5. Maintains detailed and accurate records of nursing actions.
6. Participates in health/therapeutic counseling, teaching, and emotional support for patients and their significant others.
7. Adapts to the needs of the unit by demonstrating flexibility/adaptability.
8. Makes rounds on assigned patients and prioritizes patient's needs.
9. Maintains a safe and clean environment for patients and co-workers.
10. Formulates, modifies and implements goal oriented patient care plans according to facility policies.
11. Provides and receives reports in status of patients at the change of shifts.
12. Administers medication and therapies within the scope of safe nursing practice.
13. Assumes responsibility to report clinical limitations or the need for assistance to the supervisor.
14. Performs all other duties as assigned by the nursing supervisor.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

- Complies with federal, state, and local legal and certification requirements by studying existing and new legislation; anticipating future legislation; enforcing adherence to requirements; advising management on needed actions.
- Contributes to team effort by accomplishing related results as needed.

**Skills/Qualifications:** Health Promotion and Maintenance, Creating a Safe, Effective Environment, Motivating Others, Legal Compliance, Bedside Manner, Medical Teamwork, Mental Health, Pain Management, Listening, Analyzing Information , Quality Focus

Employee Printed Name: \_\_\_\_\_

Date:\_\_\_\_\_

Employee Signature:\_\_\_\_\_



14902, Shelborne Road,  
Westfield, IN 46074

Ph: (317)286-2885  
Fax: (317)536-3097  
info@rehabilitycare.com  
www.RehabilityCare.com

### Reference Form

---

Clinician Name: \_\_\_\_\_ Date of Evaluation: \_\_\_\_\_

Company: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_ Title: \_\_\_\_\_

Phone #: \_\_\_\_\_ Signature: \_\_\_\_\_

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_ Specialty: \_\_\_\_\_

# of Beds: \_\_\_\_\_ Unit Description: \_\_\_\_\_

Eligible for Re-hire: \_\_\_\_\_ Avg. Patient Caseload: \_\_\_\_\_

#### EVALUATION:

Ratings: 4 = Outstanding 3 = Exceeds Expectation 2 = Meets job Requirement 1 = Not Met

Performance	Outstanding	Exceeded Expectation	Meets Job Requirements	Not Met
Job Knowledge				
Work Quality				
Initiative				
Dependability				
Creativity				
Accepts Directions				
Interpersonal Relationship				
Accurate Documentation				
Communicate Effectively				
Attendance				
Punctuality				

Signature of Employee: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_



**EMPLOYEE AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION ON EMPLOYMENT FILE, BACKGROUND CHECK, MEDICAL RECORDS, RANDOM DRUG SCREENING, AND PAYCHECK DEDUCTIONS:**

By affixing my signature hereunder, I authorize REHABILITY CARE to release any and all confidential employment, background check and medical information contained in my employment file to any medical facility or entity with whom REHABILITY CARE has a staffing agreement, and to any other governmental or regulatory agency at such agency's request. For all other purposes, shall keep my employment records confidential and shall advise any medical facility or other entity to REHABILITY CARE whom records have been provided to also keep such records confidential. I hereby hold REHABILITY CARE harmless for any result(s) that arise with regards to the release of this confidential

Information by REHABILITY CARE.

Medical records information is confidential and REHABILITY CARE will instruct client facilities and/or other entities to treat the provided information confidential as well. I consent to a urine, blood or breath sample for the purposes of an alcohol, drug, intoxicant, or substance abuse screening tests. Furthermore, I consent to the release of the test results for purposes of determining the fitness for employment or continued employment.

I authorize REHABILITY CARE to deduct from my paycheck for any of the following: unpaid single-supplement housing expenses being the cost incurred for rooming by oneself instead of sharing a room with a roommate, non-authorized housing expenses including but not limited to housing items taken from room(s) or other provided housing, telephone and fax charges to room left unpaid at time of departure, any other room service charges such as movie rentals or dry cleaning costs, any damage/destruction done to room or other housing, and any other expenses due and owing to REHABILITY CARE.

My signature hereunder further indicates that I have read the EMPLOYEE AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION ON EMPLOYMENT FILE, BACKGROUND CHECK, MEDICAL RECORDS, RANDOM DRUG SCREENING AND DEDUCTION FROM PAYCHECK POLICY in its entirety and understand its contents.

I understand that my employment is "at will" and may be terminated by me or REHABILITY CARE at any time, with or without prior notice, for any lawful reason or no reason. I further understand no contract is intended by me or REHABILITY CARE and as such my employment is not governed by any contractual relationship with REHABILITY CARE. I certify that the facts contained in this application are true and accurate. I understand that any misrepresentation or omission of facts is cause for dismissal. I authorize the employer to investigate any and all statements contained herein and request the persons, firms, and/or corporations named above to answer any and all questions relating to this application. I release all parties from all liability, including but not limited to, the employer and any person, firm or corporation who provides information concerning my prior education, employment or character.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

*REHABILITY CARE does not discriminate in respect to hiring, firing, compensation, and all other terms and conditions of privileges of employment on the basis of race, color, national origin, ancestry, sex, age, pregnancy or related medical conditions, marital status, religious creed, or disability.*



I hereby authorize the release of any information requested on this form. I also release the person / facility below from all liability in providing any type of reference information.

Applicant Signature \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date \_\_\_\_\_

**\*\*Do not write below this line\*\***

Dear \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ has applied for employment with us. We would appreciate your cooperation in verifying or correcting the enclosed information and answering the following questions. Please return this self addressed letter to us as soon as possible. All information is confidential. Thank you for your assistance.

Employed from \_\_\_\_\_ to \_\_\_\_\_

Position(s) held \_\_\_\_\_

Applicant's reason for leaving \_\_\_\_\_

Subject to re-hire \_\_\_\_\_ If no, why not? \_\_\_\_\_

Facility / Company \_\_\_\_\_

Signature/Title \_\_\_\_\_ Date \_\_\_\_\_

☐ Telephone Reference

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of person taking information

Date





## **PREVENTING AND ADDRESSING SEXUAL HARASSMENT AND UNLAWFUL DISCRIMINATION**

The Company is committed to working with Client healthcare facilities to provide a work environment that is free of harassment and discrimination. In keeping with this commitment, we do not tolerate any form of sexual harassment or any other form of unlawful discrimination.

Harassment based on race, sex, national origin, disability, sexual orientation; religion or other protected characteristic is a violation of state and federal laws. State and federal laws define sexual harassment to include unwelcome sexual advances, requests for sexual favors, and other verbal, visual, or physical conduct of a sexual nature. Any person who commits such a violation may be subject to personal liability as well as disciplinary actions, up to and including termination.

Sexual harassment of employees by supervisors, co-workers or clients/customers is strictly prohibited. Such conduct is unlawful when:

- ◆ Submission to the conduct is made a term or condition of employment;
- ◆ Submission to or rejection of the conduct is used as the basis for an employment decision affecting an employee; or
- ◆ The conduct has the purpose or effect of unreasonably interfering with an employee's work performance, or creating an intimidating, hostile, or offensive work environment.

Examples of sexual harassment include unwelcome sexual flirtations, advances or propositions; verbal abuse of a sexual nature; subtle pressure or requests for sexual favors; unnecessary touching of an individual; a display in the workplace of sexually suggestive objects or pictures; sexually explicit or offensive jokes; or a physical assault.

If at anytime on your assignment you believe that you are being subjected to discrimination or harassed in any way, please express your assessment of remarks made or actions taken as "harassment," or "discrimination" and the facts of the incident(s) to your direct supervisor, the house supervisor, or, if you prefer, the assignment facility's Human Resources department.

In many situations, individuals are insensitive to the offensiveness of their words or behaviors, but will cease the offensive behavior when its impact is brought to their attention. Try this approach, bearing in mind that what is acceptable in one environment may not be acceptable in another.

While working as a Traveler you may find environments that are less tolerant of “kidding around” and “teasing” than you have been used to, or you may find yourself uncomfortable in an environment that is far more tolerant of “kidding around” or “teasing” than you have worked in before. In this situation, make your discomfort known through the appropriate chain of command at the healthcare facility.

If the situation is not resolved to your satisfaction, please report the facts of the incident(s) to the Clinical Liaison who will immediately investigate any complaint and work with the assignment facility to define and initiate appropriate preventive and/or corrective action(s).

No Traveler or corporate staff employee will be retaliated against for making a complaint or bringing inappropriate conduct to the Company’s attention, for preventing unlawful practices, or for participating in an investigation, proceeding, or hearing conducted by any governmental agency.

***TRAVELERS:***

- 1. Be aware that as a Traveler you will be viewed as a “newcomer,” and may not ever become part of the facility’s social “family.” Be especially conscious of this status in your words and actions, taking care never to say or do anything that could be viewed as “in poor taste” or construed as harassing behavior. Always keep in mind that what is acceptable in one environment may not be acceptable in another, and that often one person’s “kidding around” or “teasing” is another person’s “harassment.”*
- 2. Show respect to everyone by refusing to participate in or tolerate inappropriate behavior.*

I have read, understood and intend to comply with these Professional Conduct Expectations.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Date



## AGE SPECIFIC JOB REQUIREMENTS

JCAHO mandates that caregivers and other facility employees are competent to provide age appropriate care and services. As a result our Client facilities require that we document your competencies for all age groups for whom you provide care.

The following highlights some of the most important caregiver actions related to the age of the patient. Identify the age groups of your patients.

### Neonates

Provide protective environment.

- ◆ Cuddle and hug the baby.
- ◆ Use pacifier and bottle as distractions.
- ◆ Position babies in supine position for sleep.
- ◆ Ensure warmth.
- ◆ Involve parents in decision making process.
- ◆ Provide parents with information about support services available to aid them to meet the needs of their baby post-discharge.

### Infants

- ◆ Keep parents in infant's line of vision within safety limits.
- ◆ Give infant a familiar object for comfort.
- ◆ Limit the number of strangers present.
- ◆ Remove equipment used and keep rail up after procedure.
- ◆ Position infant in supine position for sleep.
- ◆ Involve parents in decision-making processes.
- ◆ Do not allow infant to routinely use a bottle as a sleeping aid.
- ◆ Provide parents with information about support services available to help them to meet the needs of their child post-discharge.

### Toddlers

- ◆ Explain what you'll do before beginning.
- ◆ Use firm, direct approach.
- ◆ Give one direction at a time.
- ◆ Prepare the child immediately before procedures.
- ◆ Allow choices when possible.
- ◆ Distract the toddler from focusing on pain or procedures.
- ◆ Use play as a means of preparation and explanation of procedures.
- ◆ Allow for religious/cultural beliefs as expressed by parents.
- ◆ Include parents in education of the toddler.
- ◆ Emphasize aspects of procedures that will require cooperation.

- ◆ Provide parents with information about support services available to help them meet the needs of their toddler post-discharge.

## **Pre-school and school-age patients**

- ◆ Explain procedure and equipment using correct terminology.
- ◆ Plan for duration of education and play sessions appropriate to child's tolerance.
- ◆ Educate using games, rewards and praise.
- ◆ Allow child to have as much control over the environment as possible.
- ◆ Explain unfamiliar objects.
- ◆ Involve child whenever possible.
- ◆ Plan procedures in advance to reduce child's waiting time.
- ◆ Allow for expressions of religious/cultural beliefs as expressed by the parents.
- ◆ Include parents in the child's education.
- ◆ Provide parents with information about support services available to help them meet the needs of their child post-discharge.

## **Adolescents**

- ◆ Include reasons in explanation of procedures.
- ◆ Encourage questions regarding the patient's fears.
- ◆ Provide privacy – especially for adolescents.
- ◆ Involve in decision making and planning.
- ◆ Expect resistance from the patient.
- ◆ Allow for religious/cultural beliefs.
- ◆ Include parents in the patient's education as appropriate to the family dynamic and medical condition of the patient.
- ◆ Provide parents and the adolescent with information about support services available to help them meet their needs after the patient's discharge.

## **Adults**

- ◆ Include reasons in explanation of procedures.
- ◆ Encourage questions regarding the patient's fears.
- ◆ Provide privacy.
- ◆ Involve in decision making and planning.
- ◆ Allow for religious/cultural beliefs.
- ◆ Bring significant others into the patient's education.
- ◆ Provide for mobility of the patient.
- ◆ Provide information to patient and members of the patient's support network about available services to help meet the patient's and their needs post-discharge.

## **Geriatrics**

- ◆ Include reasons in explanation of procedures.
- ◆ Encourage questions regarding patient's fears.
- ◆ Provide privacy.
- ◆ Speak distinctly.
- ◆ Focus light directly on objects.
- ◆ Slow the pace of explanations and presentations.

- ◆ Ensure warmth.
- ◆ Involve in decision making and planning.
- ◆ Provide for mobility of patient.
- ◆ Change patient positions slowly due to decreased circulatory force.
- ◆ Involve patient or designated individual in decisions involving treatment plan.
- ◆ Consider ability to chew, taste, see, hear, and think and remember in seeking patient's cooperation and in patient teaching.
- ◆ Provide information about support services to help caretakers and other family members meet the patient's and their needs post-discharge.

I have read, understood and intend to comply with these professional conduct expectations.

---

Nurse Associate Signature

---

Date

---

Please Print Name

---

Date



## Physicians Statement

*The section below is to be completed by employee.*

### Medical Release Authorization:

I \_\_\_\_\_ do hereby authorize \_\_\_\_\_ to release any information  
(Applicant Name) (Physicians Name)  
acquired during my medical examination to Rehability Care. Furthermore I authorize Rehability Care to release any information on this statement, relevant to employment, to any of its client facilities. I understand this must be completed before I can begin work with Rehability Care.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

*The section below is to be completed by physician or staff.*

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Pupils:** Equal \_\_\_\_ Unequal \_\_\_\_

**Blood Pressure:** \_\_\_\_\_ **Heart Rate:** \_\_\_\_\_ **Pulse:** \_\_\_\_\_

<b>MEDICAL:</b>	NORMAL	ABNORMAL	COMMENTS
Appearance	_____	_____	_____
Eyes/ears/nose/throat	_____	_____	_____
Hearing	_____	_____	_____
Lymph nodes	_____	_____	_____
Heart	_____	_____	_____
Lungs	_____	_____	_____
Abdomen	_____	_____	_____
Genitalia (males only)	_____	_____	_____
Skin	_____	_____	_____
<b>MUSCULOSKELETAL:</b>	_____	_____	_____
Neck	_____	_____	_____
Back	_____	_____	_____
Shoulder/Arm	_____	_____	_____
Elbow/forearm	_____	_____	_____
Wrist/hand/fingers	_____	_____	_____
Hip/thigh	_____	_____	_____
Knee	_____	_____	_____
Leg/ankle	_____	_____	_____

I have examined this patient and determined that this person is in good physical health, free of communicable diseases and is able to function and perform all job duties without any physical limitations in his/her profession at full capacity.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Physicians Medical ID Number

\_\_\_\_\_  
Physician Phone

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

Date of exam: \_\_\_\_\_ Time of exam: \_\_\_\_\_



## Hepatitis B Vaccination Fact Sheet

### **The Vaccine:**

Engerix-B (Hepatitis B Vaccine-Recombinant) is a noninfectious, Recombinant DNA hepatitis B vaccine. Over several studies, at least 90% of the individuals immunized have been seroprotected. Duration of protection by the vaccine has not been fully defined and is still being studied; however, in one study 76% of the immunized individuals had titers high enough to be considered immune for 10 years after vaccination.

Persons with immune deficiency problems should obtain a written release from their physician prior to receiving the vaccine. Persons with known allergies to yeast may require a different form of the vaccine known as "Hepatitis B Virus Vaccine (Plasma-derived).

### **Benefits to Recipients:**

The hepatitis B vaccine provides protection against acquiring the hepatitis B virus. It is especially recommended to those individuals who have occupational exposure to blood of other potentially infectious materials. Although most people who acquire hepatitis recover fully, about 10% become chronic carriers of the disease and 1-2% die of fulminant hepatitis. There also has been an association between hepatitis B virus and the development of liver cancer and/or cirrhosis of the liver. Thus the vaccine and the vaccination offer a method of protection, free of charge to the Access Therapies employee, from acquiring hepatitis B at work or elsewhere.

### **Possible Adverse Reactions:**

Engerix-B (Hepatitis B Vaccine-Recombinant) is generally well tolerated. No substances of human origin are used in its manufacture. Adverse reactions, if any, to the vaccines are generally mild, infrequent, and transient. As with any vaccine, however, it is possible that expanded commercial use of the vaccine could reveal rare adverse reactions not observed in clinical studies.

The most frequently reported adverse reactions include: injection site soreness, fatigue, weakness, induration, erythema, swelling, fever, headache, and dizziness. Adverse reactions of a more serious nature have been reported, but with a frequency of less than 1% of the immunized population. If there are any further questions regarding adverse reactions of the vaccine, ask your supervisor.

### **Contraindications:**

Not to be used in persons with a known allergy/hypersensitivity to yeast and/or other components of the vaccine. The vaccine should be administered with caution to any person known to have thrombocytopenia or bleeding disorder. These persons should have the vaccination administered via the subcutaneous versus the intramuscular route.

### **Dosing Schedules:**

Three doses of the hepatitis B vaccine are required to confer immunization against infection. "Engerix-B" is administered on a selected date, then again at one-month and at six-months from the date of the first injection.

### **Pregnancy, Fertility and Lactation:**

Since animal reproduction studies have not been carried out on "Engerix-B", the vaccine should be given to pregnant women only when clearly indicated. It is also not known whether the vaccine can cause any harm to the fetus when administered to a pregnant woman. It is not known if the vaccine affects fertility. Finally, it is not known if the vaccine is excreted in human breast milk. Because many drugs are excreted in human breast milk, caution should be used when considering administering the vaccine to a nursing mother.



## **HEPATITIS B VIRUS VACCINE CONSENT/DECLINATION**

Please sign and date EITHER the verification OR declination.  
DO NOT SIGN BOTH.

### **BLOODBORNE PATHOGENS**

I HAVE BEEN INFORMED OF THE SYMPTOMS AND MODES OF TRANSMISSION OF BLOODBORNE PATHOGENS INCLUDING HEPATITIS B VIRUS (HBV). I KNOW ABOUT THE AGENCY'S INFECTION CONTROL PROGRAM AND UNDERSTAND THE PROCEDURE TO FOLLOW IF AN EXPOSURE INCIDENT OCCURS.

### **HEPATITIS B VACCINE VERIFICATION**

I fully understand that my occupation may lead to exposure of blood or other potentially infectious materials. I may be at risk of acquiring Hepatitis B infection. I was vaccinated for Hepatitis B (HBV) in the past (ALL 3 vaccines) and the date of my last vaccination was \_\_\_\_\_. I will provide all records of previous of Hepatitis B vaccinations.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

### **HEPATITIS B VACCINE DECLINATION**

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I choose to be vaccinated for Hepatitis B, I will pursue the vaccination series

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name





## Tuberculosis Screening Questionnaire / TB (PPD) Skin Test

***The section below is to be completed by employee.***

Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_ Discipline: \_\_\_\_\_

Have you ever had a positive TB Skin Test (PPD) Result: Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes; date of last chest X-Ray: \_\_\_\_\_

**Screening Questionnaire:** Please indicate if you have had any of the following problems for three weeks or longer:

	Yes	No	Comments
Chronic Cough (greater than 3 weeks):			
Production of Sputum:			
Blood Streaked Sputum:			
Unexplained Weight Loss:			
Fever:			
Fatigue/Tiredness:			
Night Sweats:			
Shortness of Breath:			

\_\_\_\_\_  
Employee Signature Date

***The section below is to be completed by persons authorized to administer and read Mantoux Skin Tests.***

Testing Location: \_\_\_\_\_ Date Placed: \_\_\_\_\_

Site: Right \_\_\_\_\_ Left: \_\_\_\_\_ Lot #: \_\_\_\_\_ Exp Date: \_\_\_\_\_

Signature (administered by): \_\_\_\_\_ RN \_\_\_ MD \_\_\_ Other \_\_\_

Date Read (within 48-72 hours of date placed): \_\_\_\_\_ Induration: \_\_\_\_\_mm

TB Skin Test / PPD (Mantoux) Result: Negative \_\_\_\_\_ Positive \_\_\_\_\_

Signature (administered by): \_\_\_\_\_ RN \_\_\_ MD \_\_\_ Other \_\_\_

***The section below is to be completed by Rehability Care***

Date Received: \_\_\_\_\_ Reviewed By: \_\_\_\_\_